COVID-19 (nCorona) Virus Outbreak Control and Prevention State Cell

Health & Family Welfare Department

Government of Kerala

GUIDELINES- ONLINE REPORTING OF COVID-19 TEST DATA

No.31/F2/2020 Health- 28th July 2020.

Kerala state has ramped up the number of tests in past few weeks and will be continuing with the same depending on the trend of the COVID epidemic in the State. Currently the COVID-19 test results are entered in Kerala state health monitoring portal "healthmon.kerala.gov.in/rapidtest" as well as in the Indian Council of Medical Research (ICMR) portal.

In order to reduce the load and efforts of meticulous data entry of COVID 19 test results, Government of Kerala in association with ICMR has established an Application Program Interface (API) for the consensual exchange and record linkage of COVID test data. With the establishment of the system, the Laboratories need to enter the testing data only on the Kerala State portal and the data will be feed forwarded to the ICMR. This will ensure that ICMR is updated on the results in real time with one point of data entry through the State portal.

1. The State portal can be assessed through https://**healthmon**.kerala.gov.in/**rapidtest**
2. The data entry shall be shared between the sample collection centres/teams and designated laboratories in case of RT-PCR, TRUENAT & CBNAAT tests for COVID-19
3. In case of Point-of-care Antigen Tests, complete data entry shall be done by the Institutions where the point-of-care antigen tests were performed.
4. SRF titled ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)-KERALA attached as **Annexure 1** shall be used with effect from 28 July 2020.
5. SRF ID must follow the pattern dd/mm/3 letter code of district where sample collection occurs/2-5letter code of collection centre/2 letter code of type of test/ 4 digit running number.
   Eg: 26/07/TVM/GH/RT/0034.

6. Data and results **(both positive and negative)** of all samples shall be entered in the portal on a real time basis
7. **Daily summary of tests** done by the laboratory (from 12 noon previous day- 12 noon of reporting day) must be entered on the state portal between 12 noon-1pm every day.

Principal Secretary

ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)- KERALA

INTRODUCTION

- This form is for collection centres/ labs to enter details of the samples being tested for Covid-19. It is mandatory to fill this form for each and every sample being tested. It is essential that the collection centres/ labs exercise caution to ensure that correct information is captured in the form. Fields marked with asterisk (*) are mandatory to be filled

- **TYPE OF TEST:** **RTPCR** ☐ **CBNAAT** ☐ **TRUENAAT** ☐ **ANTIGEN** ☐
- **TYPE OF SAMPLE** **Routine Sample** ☐ **Sentinel Surveillance Sample** ☐

SECTION A – PATIENT DETAILS

A.1 TEST INITIATION DETAILS

***Doctor Prescription: Yes** ☐ **No** ☐
(If yes, attach prescription; If No, test cannot be conducted)

***Follow up Sample: Yes** ☐ **No** ☐
If Yes, Patient ID: .....

A.2 PERSONAL DETAILS

*** Patient Name:** .....
***Patient in quarantine facility: Yes** ☐ **No** ☐
*** Present Village or Town:** .....
*** District of Present Residence:** .....
*** State of Present Residence:** .....
*** Present patient address:** .....
.....
Pincode: ☐☐☐☐☐☐

***Age: .... Years/Months** ☐ **age <1 yr, pls. tick months checkbox)**
*** Gender: Male** ☐ **Female** ☐ **Others** ☐
*** Mobile Number:** ☐☐☐☐☐☐☐☐☐☐
***Mobile Number belongs to: Self** ☐ **Family** ☐
*** Nationality:** .....
***Downloaded Aarogya Setu App: Yes** ☐ **No** ☐
(These fields to be filled for all patients including foreigners)

Aadhar No. (For Indians) ☐☐☐☐☐☐☐☐☐☐☐☐
Passport No. (For Foreign Nationals): .....

* A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

***Specimen type** Throat Swab ☐ Nasal Swab ☐ BAL ☐ ETA ☐ Nasopharyngeal swab ☐
*** Collection date** ____ ____ ____ ____ ____
*** Sample ID (Label)/ SRF ID** ☐☐☐☐

* A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

Cat 1: Symptomatic international traveller in last 14 days ☐
Cat 2: Symptomatic contact of lab confirmed case ☐
Cat 3: Symptomatic Healthcare worker / Frontline workers ☐
Cat 4: Hospitalized SARI (Severe Acute Respiratory Illness) patient ☐
Cat 5a: Asymptomatic direct and high risk contact of lab confirmed case - family member ☐
Cat 5b: Asymptomatic healthcare worker in contact with confirmed case without adequate protection ☐
Cat 6: Symptomatic Influenza like Illness (ILI) in Hospital ☐
Cat 7: Pregnant woman in / near labour ☐
Cat 8: Symptomatic (ILI) among returnees and migrants (within 7 days of illness) ☐
Cat 9: Symptomatic Influenza Like Illness(ILI) patient in Hotspot / Containment zones ☐
Other: (please specify) * *(Select "other" only if the patient doesn't belong to category 1-8 or sentinel surveillance sample)* ☐

SECTION B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Symptoms: Yes ☐ NO ☐ If No please go to B.2 section

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

Which of the above mentioned was First Symptom:..... Date of onset of First Symptom: ☐☐ ☐☐ ☐☐ (dd/mm/yy)

.....

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung disease	☐	Malignancy	☐	Heart disease	☐	Chronic liver disease	☐
Chronic renal disease	☐	Diabetes	☐	Hypertension	☐		

Immunocompromised condition: YES ☐ NO ☐ Other underlying conditions: .....

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ No ☐

HospitalID/number

Hospitalization Date: ☐☐/☐☐/☐☐ (dd/mm/yy)

Hospital State: .....

Hospital District: .....

Hospital Name: .....

B.4 REFERRING DOCTOR DETAILS

*Name of Doctor: .....

Doctor Mobile No.: .....

Doctor Email ID: .....

** Fields marked with asterisk are mandatory to be filled*

TEST RESULT (To be filled by Covid-19 testing lab facility)

Date of sample receipt(dd/mm/yy)	Sample accepted/ Rejected	Date of Testing (dd/mm/yy)	Test result (Positive / Negative)	Repeat Sample required (Yes / No)	Sign of Authority (Lab incharge)

SRF ID/SAMPLE ID ----------

DESIGNATED LABORATORY----------